IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

November 3, 2010

Merinda Halladay, Administrator
Belmont Care Center Crestview
3625 Vaughn Street
Pocatello, ID 83204

RE: Belmont Care Center Crestview, Provider #13G050

Dear Ms. Halladay:

This is to advise you of the findings of the Medicaid/Licensure survey of Belmont Care Center Crestview, which was conducted on October 21, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner**:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of

being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **November 15, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by November 15, 2010. If a request for informal dispute resolution is received after November 15, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/srm
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G050	A. BUILDING _____ B. WING _____	10/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT CARE CENTER CRESTVIEW	4024 MOUNTAIN LOOP POCATELLO, ID 83204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during your recertification survey. The survey was conducted by: Jim Troutfetter, QMRP Common abbreviations/symbols used in this report are: BID - Twice per Day HRC - Human Rights Committee HS - Hour of Sleep IPP - Individual Program Plan LPN - Licensed Practical Nurse PSA - Prostrate Specific Antigen QMRP - Qualified Mental Retardation Professional RN - Registered Nurse TID - Three Times per Day	W 000	**Preparation and implementation of this plan of correction does not constitute admission or agreement by Belmont Management with the facts, findings, or other statements as alleged by the Bureau of Facility Standards concluded on October 21st, 2010. Submission of this plan of correction is required by law and does not evidence the truth of some of the findings as stated by the survey agency. Belmont Management specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action.**	
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review, and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only with the approval of the facility's HRC for 2 of 4 individuals (Individuals #1 and #3) whose consents were reviewed. This resulted in the potential for individuals to receive unnecessary medications. The findings include:	W 262	**POC W262 483.440(f)(3)(i)** **Program Monitoring & Change** Belmont will ensure that HRC approval is obtained and kept current for all restrictive medications and interventions. Nursing will ensure that prior to the implementation of a restrictive medication the Human Rights Committee has given approval. The Behavior Specialist will meet monthly with the Human Rights Committee to review any proposed implementation or changes to restrictive medications and interventions. Person Responsible: Behavior Specialist, LPN, RN, QMRP(s) and Administrator	12/18/10

FACILITY STANDARDS
NOV 15 2010
RECEIVED

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheri Howard — TITLE: Program Director — (X6) DATE: 11/12/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G050	A. BUILDING _____ B. WING _____	10/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT CARE CENTER CRESTVIEW	4024 MOUNTAIN LOOP POCATELLO, ID 83204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 262	Continued From page 1 1. Individual #1's IPP, dated 2/9/10, documented a 51 year old male diagnosed with severe mental retardation and autism. His record contained a Physician's order, dated August 2010, documenting he received Risperdal (an antipsychotic drug) 1 mg TID, Cogentin (an antiparkinsonian drug) 1 mg BID, and Naltrexone (an opioid antagonist drug) 25 mg HS. However, his record did not contain current HRC consent for the drugs. 2. Individual #3's IPP, dated 4/27/10, documented a 50 year old male diagnosed with mild mental retardation and paranoid schizophrenia. His record contained a Physician's order, dated August 2010, documenting he received Zyprexa (an antipsychotic drug) 10 mg HS. However, his record did not contain current HRC consent for Zyprexa. When asked during an interview on 10/21/10, from 10:55 - 11:05 a.m., the Administrator stated Individual #1 and #3 did not have current HRC consents for the drugs. The facility failed to obtain HRC consent for the use of behavior modifying drugs.	W 262	***CONTINUED POC W262 483.440(f)(3)(i) Program Monitoring & Change*** Monitor: The Behavior Specialist will maintain a list of restrictive medications and interventions with the expiration date. This list will be reviewed monthly in Behavior Meeting along with any consents that may expire. In addition, the Behavior Specialist will maintain a list of proposed restrictive medications and interventions to take to the Human Rights Committee. Once approval is given the Behavior Specialist will notify the QMRP and Nursing. A copy of the updated lists will then be given to the OMRP and Nursing staff.	12/13/10
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by:	W 263	**POC W263 483.440(f)(3)(ii) Program Monitoring & Change** Belmont will ensure written informed consent from the client/guardian is obtained and kept current for all restrictive medications and interventions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G050	A. BUILDING _____ B. WING _____	10/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT CARE CENTER CRESTVIEW	4024 MOUNTAIN LOOP POCATELLO, ID 83204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 2 Based on record review, and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the written informed consent of an appropriate person for 2 of 2 individuals (Individuals #1 and #3) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior approval of restrictive interventions. The findings include: 1. Individual #1's IPP, dated 2/9/10, documented a 51 year old male diagnosed with severe mental retardation and autism. His record contained a Physician's order, dated August 2010, documenting he received Risperdal (an antipsychotic drug) 1 mg TID, Cogentin (an antiparkinsonian drug) 1 mg BID, and Naltrexone (an opioid antagonist drug) 25 mg HS. However, his record did not contain current guardian consent for the drugs. 2. Individual #3's IPP, dated 4/27/10, documented a 50 year old male diagnosed with mild mental retardation and paranoid schizophrenia. His record contained a Physician's order, dated August 2010, documenting he received Zyprexa (an antipsychotic drug) 10 mg HS. However, his record did not contain current guardian consent for Zyprexa. When asked during an interview on 10/21/10, from 10:55 - 11:05 a.m., the Administrator stated Individual #1 and #3 did not have current guardian consents for the drugs. The facility failed to obtain guardian consent for	W 263	***CONTINUED POC W263 483.440(f)(3)(ii) Program Monitoring & Change*** Nursing will ensure that prior to the implementation of a restrictive medication the client/guardian has given approval. The Behavior Specialist will contact the individual/guardian to review any proposed implementation or changes to restrictive medications and interventions. The Behavior Specialist will ensure the individual/guardian is given written informed information to make their decision. Person Responsible: Behavior Specialist, LPN, RN, QMRP(s) and Administrator Monitor: The Behavior Specialist will maintain a list of restrictive medications and interventions with the expiration date. This list will be reviewed monthly in Behavior Meeting along with any consents that may expire. In addition, the Behavior Specialist will maintain a list of proposed restrictive medications and interventions in order to contact the individual/guardian and obtain approval prior to the implementation of the restrictive medication or intervention. Once approval is given the Behavior Specialist will notify the QMRP and Nursing. A copy of the updated lists will then be given to the OMRP and Nursing staff.	12/10/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G050	A. BUILDING _____ B. WING _____	10/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT CARE CENTER CRESTVIEW	4024 MOUNTAIN LOOP POCATELLO, ID 83204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 3 the use of behavior modifying drugs.	W 263		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure adequate general and preventative medical care was provided for 2 of 4 individuals (Individual #1 and #2) whose health screenings were reviewed. This resulted in the potential for individuals to not receive adequate medical care. The findings include: 1. Individual #2's IPP, dated 10/12/10, documented a 69 year old male diagnosed with profound mental retardation. His record contained a Physician's order, dated August 2010, documenting he was receiving metoclopramide (a gastrointestinal tract drug) 5 mg before meals and HS. The 2010 Nursing Drug Handbook documents tardive dyskinesia (a condition involving abnormal involuntary movements) as a possible adverse reaction of metoclopramide. However, Individual #2's record did not contain evidence of a tardive dyskinesia evaluation. When asked on 10/19/10 at 11:23 a.m., the RN stated Individual #2 had not received an evaluation for tardive dyskinesia. The facility failed to ensure a tardive dyskinesia	W 322	**POC W322 483.460(a)(3)** **Physician Services** Belmont will ensure that each individual receives the services indicated by his/her health status. Belmont will ensure that each resident receives the medical services necessary to maintain an optimum level of health care. Nursing will ensure that there is follow-up to recommendations for referrals to specialists, specific examinations or evaluations, and treatments. Nursing will review the resident's appointment notes weekly, and ensure all necessary follow-ups are scheduled and/or completed. Person Responsible: LPN, RN, Nurse's Assistant, and Administrator Monitor: Each time a new prescription is issued, the Primary Care Nurse will research any possible side effects to assure that any additional testing or assessments need to accompany the new medication. The Primary Care Nurse will schedule and arrange any necessary assessments, evaluations, or treatments needed for each resident prior to the implementation of a new medication. At least yearly when new drug guide revisions are made, the Primary Care Nurse will review the guide for new side effects for existing prescriptions of the residents.	12/19/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G050	A. BUILDING _____ B. WING _____	10/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT CARE CENTER CRESTVIEW	4024 MOUNTAIN LOOP POCATELLO, ID 83204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 4 evaluation was completed for Individual #2. 2. Refer to W325 as it relates to the facilities failure to ensure routine or annual examinations.	W 322		
W 325	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure routine screening laboratory examinations were provided to 1 of 4 individuals (Individual #1) whose laboratory records were reviewed. This resulted in the potential for medical concerns to go undetected. The findings include: 1. Individual #1's IPP, dated 2/9/10, documented a 51 year old male diagnosed with severe mental retardation and autism. His record contained a Physician's order, dated August 2010, documenting he was to receive a PSA annually starting at age 50 and occult blood tests 3 times per year after age 50. However, his record did not contain evidence of occult blood or PSA tests. When asked on 10/19/10 at 2:55 p.m., the LPN stated Individual #1 did not receive occult blood tests or a PSA test. The facility failed to ensure Individual #1 received	W 325	**POC W325 483.460(a)(3)(iii)** **Physician Services** Belmont will ensure that each resident receives an annual physical examination that includes routine screening laboratory examinations as determined necessary by the physician. The nursing staff will ensure that all necessary laboratory examinations are completed annually, or as recommended or ordered by the primary care physician. Person Responsible: LPN, RN, Nurse's Assistant, and Administrator Monitor: The Primary Care Nurse will review the Laboratory and Immunization Chart monthly. This chart will be kept in each resident's nursing book, and includes the names of each laboratory examination ordered and/or recommended by the physician, and the month and year that the test must be completed in. This will also include laboratory examinations required when the residents are of a certain age. The Primary Care Nurse is responsible for ensuring that each resident's laboratory examinations are completed as ordered by the physician, and in accordance to the Laboratory and Immunization Chart.	12/18/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G050	A. BUILDING _____ B. WING _____	10/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT CARE CENTER CRESTVIEW	4024 MOUNTAIN LOOP POCATELLO, ID 83204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 325	Continued From page 5 occult blood tests and an annual PSA test.	W 325		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure individuals' adaptive equipment was periodically assessed and kept in good repair for 2 of 4 individuals (Individuals #2 and #6) who required adaptive equipment for mobility. This resulted in individuals' wheelchairs being in disrepair. The findings include: 1. During an observation conducted on 10/19/10, from 6:30 - 8:05 a.m., the following was noted: - Individual #2's wheelchair was missing the foot rests. When asked on 10/19/10 at 6:42 a.m., the staff present stated the foot rests had been missing for at least six months. Additionally, the brake for the left wheel was noted to be inoperable. - Individual #6: The left arm rest of his wheelchair was torn. When asked during an interview on 10/21/10, from 10:55 - 11:05 a.m., the Administrator stated Individual #2 should have foot rests and and they were having difficulties obtaining service from a	W 436	**POC W436 483.470(g)(2)** **Space and Equipment** Belmont will ensure that adaptive devices identified by the interdisciplinary team, physician, and/or Physical Therapist as needed by the resident are furnished and maintain in good repair. Belmont will ensure that each resident is taught to use and make informed choices regarding the use of adaptive equipment. The QMRP(s) will ensure that adaptive devices necessary to increase functionality are available for each resident. The QMRP(s) will assess the residents' use of adaptive devices, and ensure programming is implemented to teach each resident to use their equipment with as much independence as possible. The QMRP(s) is responsible for ensuring that adaptive devices are repaired in a timely manner, with temporary replacement devices available to each resident if needed. Person Responsible: Floor Leader, Home Supervisor(s), LPN, RN, Nurse's Assistant, QMRP(s), and Administrator Monitor: The Home Supervisor and/or Floor Leader will complete an Adaptive Equipment Concern form when an adaptive device is in ill repair and/or damaged, and when the need for a new device is identified. For repairs, The QMRP(s) will contact a local vendor to report the issue. If the repair	12/18/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G050	A. BUILDING _____ B. WING _____	10/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT CARE CENTER CRESTVIEW	4024 MOUNTAIN LOOP POCATELLO, ID 83204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 6 local provider. The facility failed to ensure individuals' wheelchairs were kept in good repair.	W 436	***CONTINUED POC W436 483.470(g)(2) Space and Equipment*** cannot be made immediately, the QMRP(s) will arrange for a replacement device until repairs can be completed. The QMRP(s) will document the date the report was received, the date and time the vendor was contacted, and the date that the repair was made. The QMRP(s) will report all requests for new adaptive devices to the treatment team. If identified as an appropriate device, the QMRP(s) will arrange for any tests/assessments needed through the physician or appropriate therapist. The QMRP(s) will also be responsible for ensuring that new adaptive devices are received in a timely manner, and arrange for necessary training with Direct Care Aides and the resident.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G050	A. BUILDING _____ B. WING _____	10/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT CARE CENTER CRESTVIEW	4024 MOUNTAIN LOOP POCATELLO, ID 83204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensing survey. The survey was conducted by: Jim Troutfetter, QMRP	M 000	RECEIVED NOV 15 2010 FACILITY STANDARDS	
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	**POC MM194 16.03.11.075.10(a) Approval of Human Rights Committee** Refer to Response W262	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196	**POC MM196 16.03.11.075.10(c) Consent of Parent or Guardian** Refer to Response W263	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean,	MM380	**POC MM380 16.03.11.120.03(a) Building and Equipment** 1. The toilet in the small bathroom will be bolted to the floor. 2. The top drawer in the small bathroom will be repaired or replaced. 3. The light to the right above the double sinks by the entry will be repaired. 4. The door to the small shower will be replaced	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G050	A. BUILDING _____ B. WING _____	10/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT CARE CENTER CRESTVIEW	4024 MOUNTAIN LOOP POCATELLO, ID 83204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 1 sanitary, and in good repair for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: An environmental review was conducted on 10/20/10 from 1:30 - 2:15 p.m. During that time, the following was noted: - The toilet in the small bathroom was not bolted to the floor. - The top drawer in the small bathroom was missing the front piece. - The light to the right above the double sinks by the entry was broken. - The right top drawer under the double sinks was missing. - The door to the small shower had a hole approximately 3 1/2 inches by 1 1/2 inches. The facility failed to ensure environmental repairs were maintained.	MM380	***CONTINUED POC MM380 16.03.11.120.03(a) BUILDING AND EQUIPMENT*** Person Responsible: Residential Home Supervisor, Floor Leader, Maintenance Supervisor, and Administrator Monitor: The Floor Leader or Home Supervisor will complete daily facility inspections. Findings will be documented on the Maintenance Concern sheet, and turned in to the Maintenance Supervisor. The Maintenance Supervisor will document the repairs needed, and the date the issue was resolved. In addition, the Maintenance Supervisor will complete monthly facility inspections, and the Administrator will complete quarterly audits.	12/18/10
MM429	16.03.11.120.11 Equipment and Supplies for Resident Care Equipment and Supplies for Resident Care. Adequate and satisfactory equipment and supplies must be provided to enable the staff to satisfactorily serve the residents. This Rule is not met as evidenced by: Refer to W436.	MM429	**POC MM429 16.03.11.120.11 Equipment and Supplies for Resident Care** Refer to Response W436	
MM735	16.03.11.270.02 Health Services	MM735	**POC MM735 16.03.11.270.02 Health Services**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G050	A. BUILDING _____ B. WING _____	10/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT CARE CENTER CRESTVIEW	4024 MOUNTAIN LOOP POCATELLO, ID 83204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM735	Continued From page 2 The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735	***CONTINUED POC MM735 16.03.11.270.02 HEALTH SERVICES*** Refer to Response W322	
MM750	16.03.11.270.02(d)(ii) Routine Screening Laboratory Examinations Routine screening laboratory examinations, as determined necessary by the physician, and special studies when the index of suspicion is high. This Rule is not met as evidenced by: Refer to W325.	MM750	**POC MM750 16.03.11.270.02(d)(ii) Routine Screening Laboratory Examinations** Refer to Response W325	